Oxford Policy Management

Learning for Action Across Health Systems

PMAC Side Meeting

29/01/2018

Time	Item	Objective	Facilitator/Speaker
9.00-9.20	Strategic context and the process of identifying an interventions	Inform the audience of the background	Alex Jones
9.20-9.40	Recommended approach 1 – top down	Outline recommendation	Ian Anderson
9.40-10.00	Recommended approach 2 – bottom up	Outline recommendation	Barbara McPake
10.00-10.30	Open discussion: Is it a good idea? Is it relevant in your context? How would they need to be organised – governance, funding, functions. *Etc.*	Gather feedback from audience	Tomas Lievens, Alex Jones and Nouria Brikci
10.30-11.00	Break		
11.00-11:30	Panel response – we've been involved, and this is how we think it will be relevant to our country	Stimulate/guide discussion	Clifford Kamara (Sierra Leone), Eusebio Chaquisse (Mozambique), Juma Kariburyo (Burundi). Chair: Nouria Brikci
11.30-12.15	Further open discussion	Gather feedback from audience	Tomas Lievens, Alex Jones and Nouria Brikci
12.15-12.30	Wrap up and closing	Inform the audience about next steps	Alex Jones

The strategic context

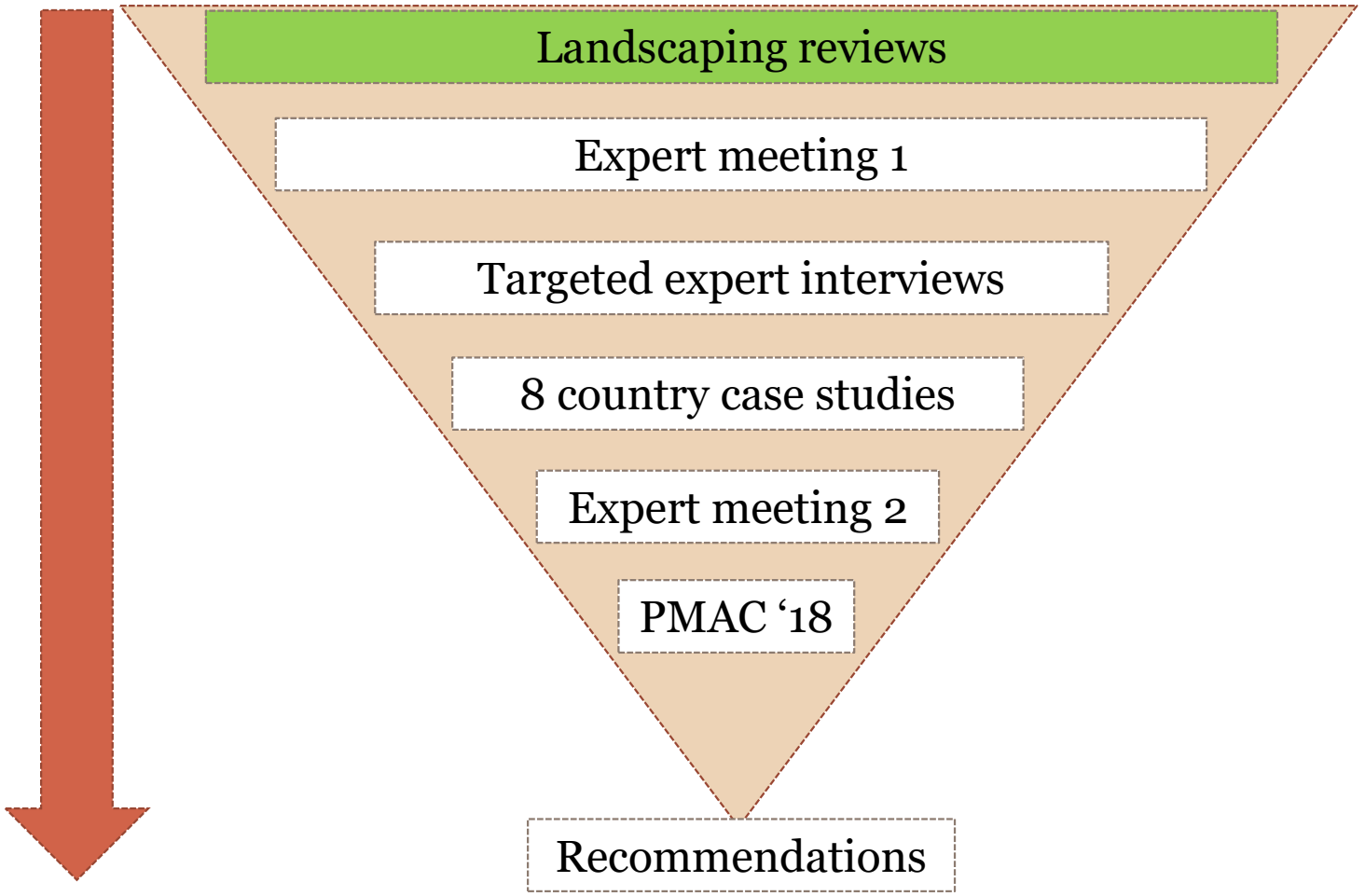
- Low and middle income countries have achieved and sustained significantly different health outcomes at different levels of national investment.

- Countries should be able to learn important lessons from each other.

- The Bill and Melinda Gates Foundation (BMGF) wishes to better understand:
  - *What* can countries learn from one another's experiences?
  - *How* do countries learn from one another's experiences?
  - *Why* do policy-makers sometimes want *or not want* to learn from one another's experience?

- Identify strategic interventions that can significantly facilitate low income countries in Sub Saharan Africa to learn from other countries as they reform their health systems.

The process of identifying strategic interventions



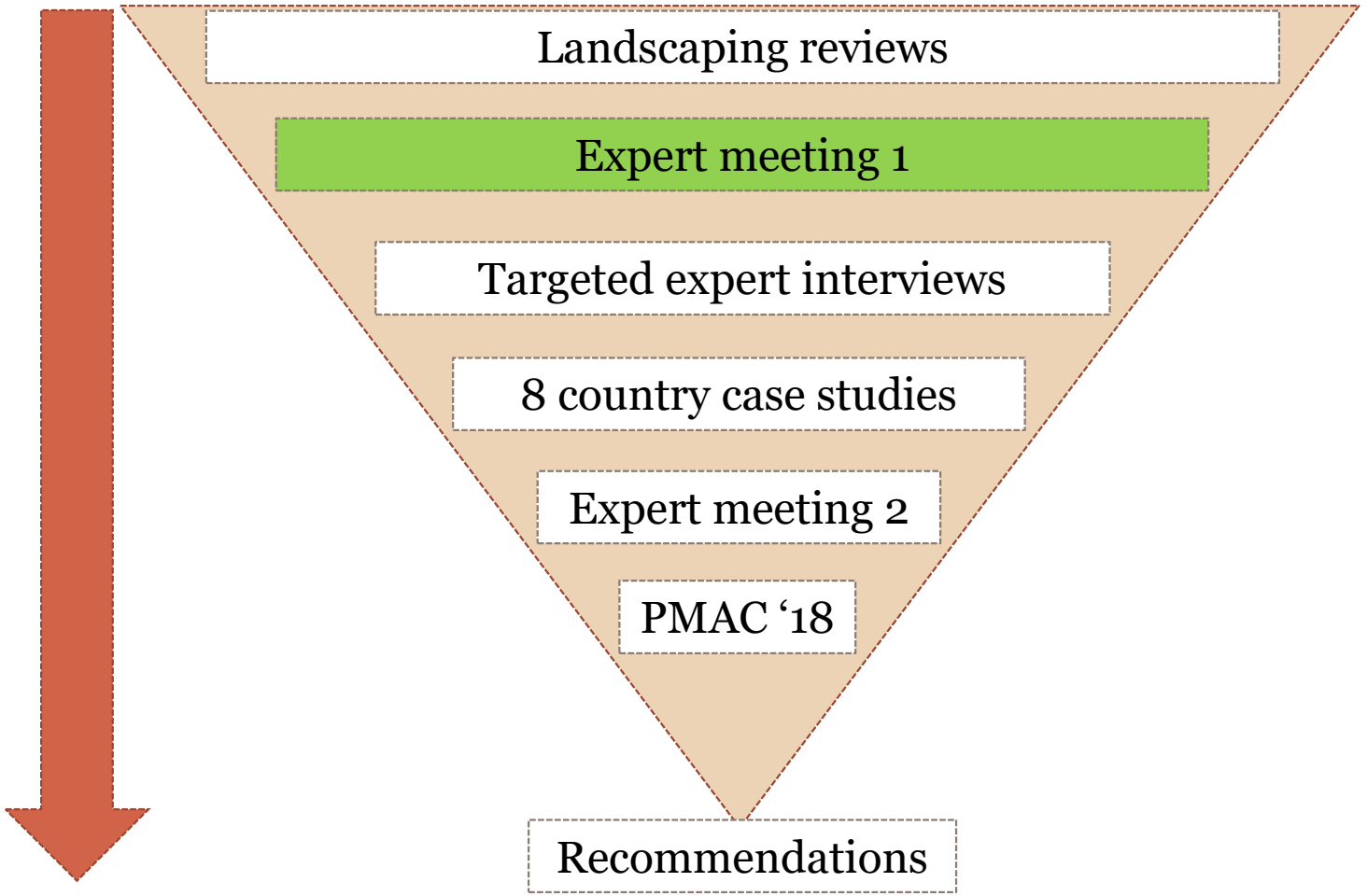
Landscaping reviews

- Part 1:
  - Comparative health systems analysis is an expanding field of empirical analysis.
  - There is a substantial body of learning from LMICs, across a range of health system elements.
  - There may be gaps in comparative literature on pharmaceutical supply chains and information systems.

- Part 2:
  - There is a large number and variety of organisations active in cross-country learning about health systems in low-income countries.
  - There is little that is publicly available about the actual or potential effectiveness of the vast majority of the 170 organisations identified

- Part 3:
  - Significant attention has been placed on the role of international organisations. individual country-to-country transfers are not as well understood.
  - Six phases of policy transfer were identified: 1) conceptualisation; 2) formation; 3) internalisation; 4) contextualisation; 5) operationalisation; and 6) evaluation.

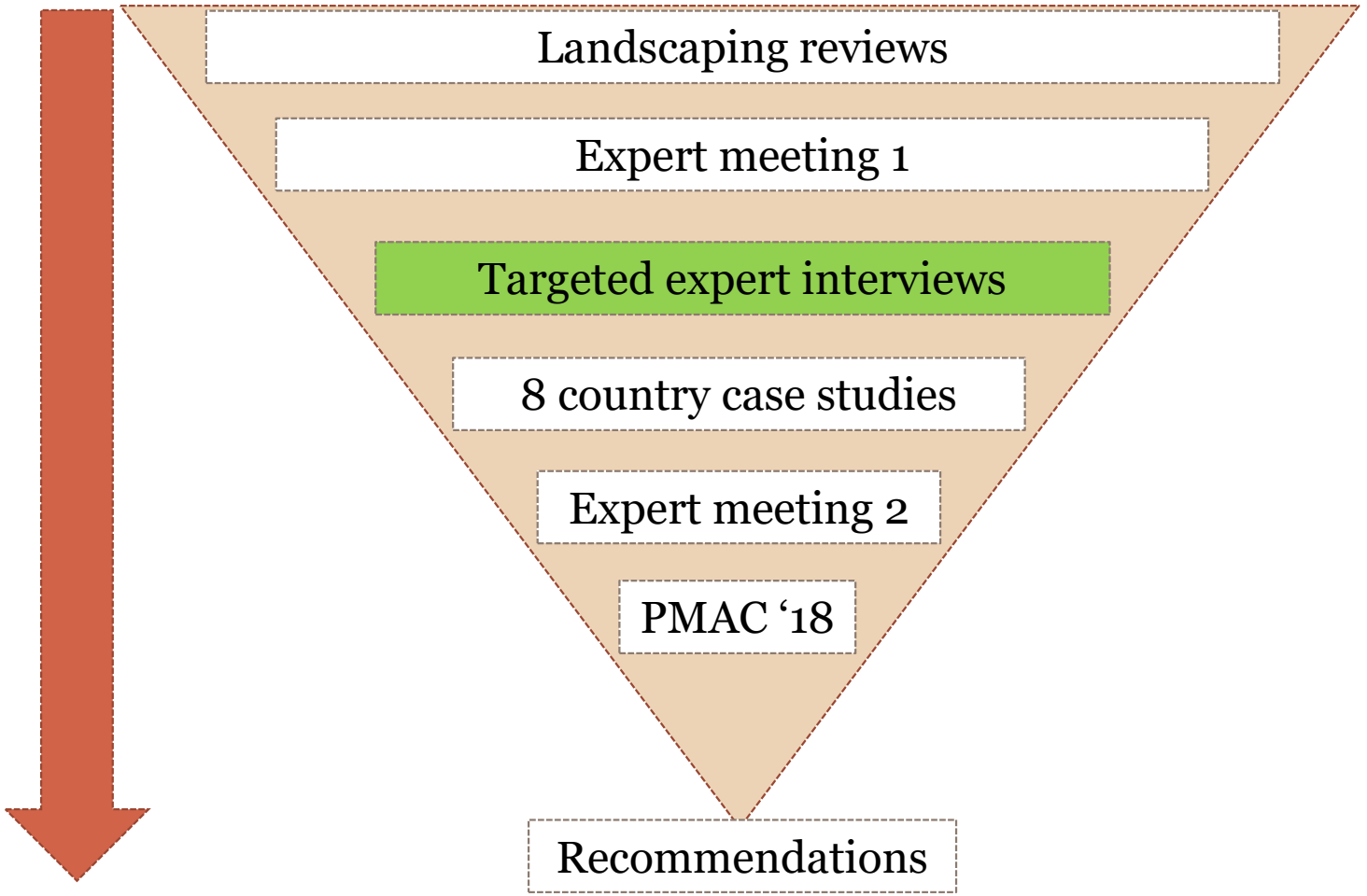
The process of identifying strategic interventions



Expert meeting 1

- Sixteen experts participated, drawn from a wide range of countries and professional experiences: policy-makers in LMICs, academics, and representatives of bilateral and multilateral organisations.
- There are many routes to learning. Different routes may be best for different countries.
- Trust, power, influence and money are all important factors within cross country learning.
- There is a proliferation of advice and ‘tools’ from multilateral and bilateral development partners. Some participants called for a ‘one-stop shop’ for evidence or ‘policy advice under one roof’.
- There is a pronounced gap in learning about implementation – the actual ‘how’ of reform in the health sector.

The process of identifying strategic interventions

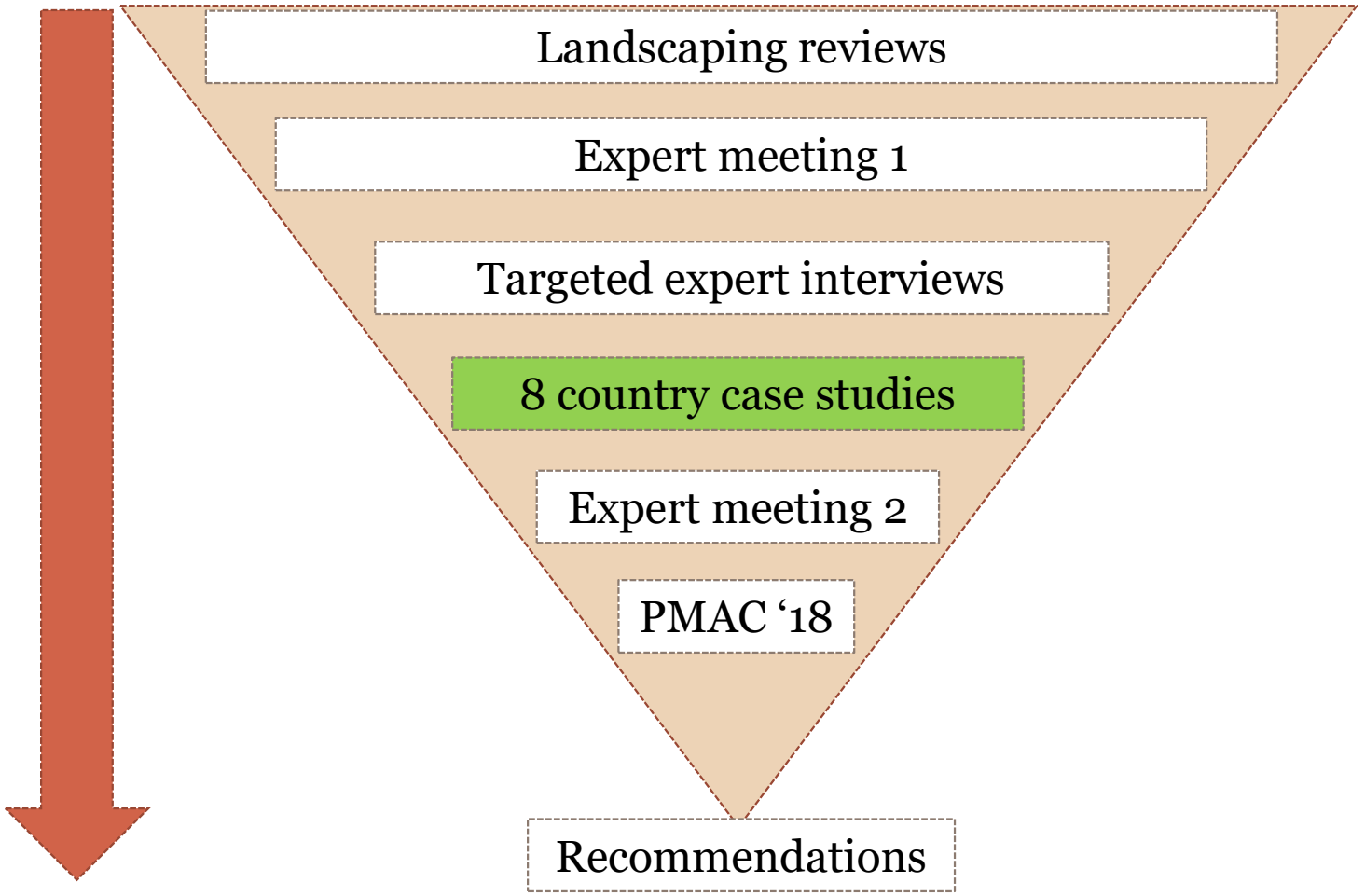


Targeted expert interviews

- REACH
- PBF Community of Practice and The Collectivity
- Collaborative African Budget Reform Initiative
- International Decision Support Initiative
- Joint Learning Initiative
- African Health Observatory (WHO/AFRO)
- Asia Pacific Observatory on Health Policies and Systems
- European Observatory on Health Systems and Policies

- Success factors:
  - Country led agenda
  - Having the right people involved
  - Buy-in and support of senior leaders
  - Peer learning
  - Legitimacy/mandate
  - Trusting relationships
- Challenges:
  - Measuring/demonstrating effectiveness
  - Funding / resources (Af Observatory, APO, REACH)
  - Moving beyond products to policy dialogue
  - Time: “To develop the culture [of evidence use in policymaking] takes a generation / 15 years”
- Little independent evaluation
- NONE mentioned in the country case studies

The process of identifying strategic interventions



8 country case studies

1-2 per country selected as ‘tracers’, based on recent (2000-2017) significant health system reforms

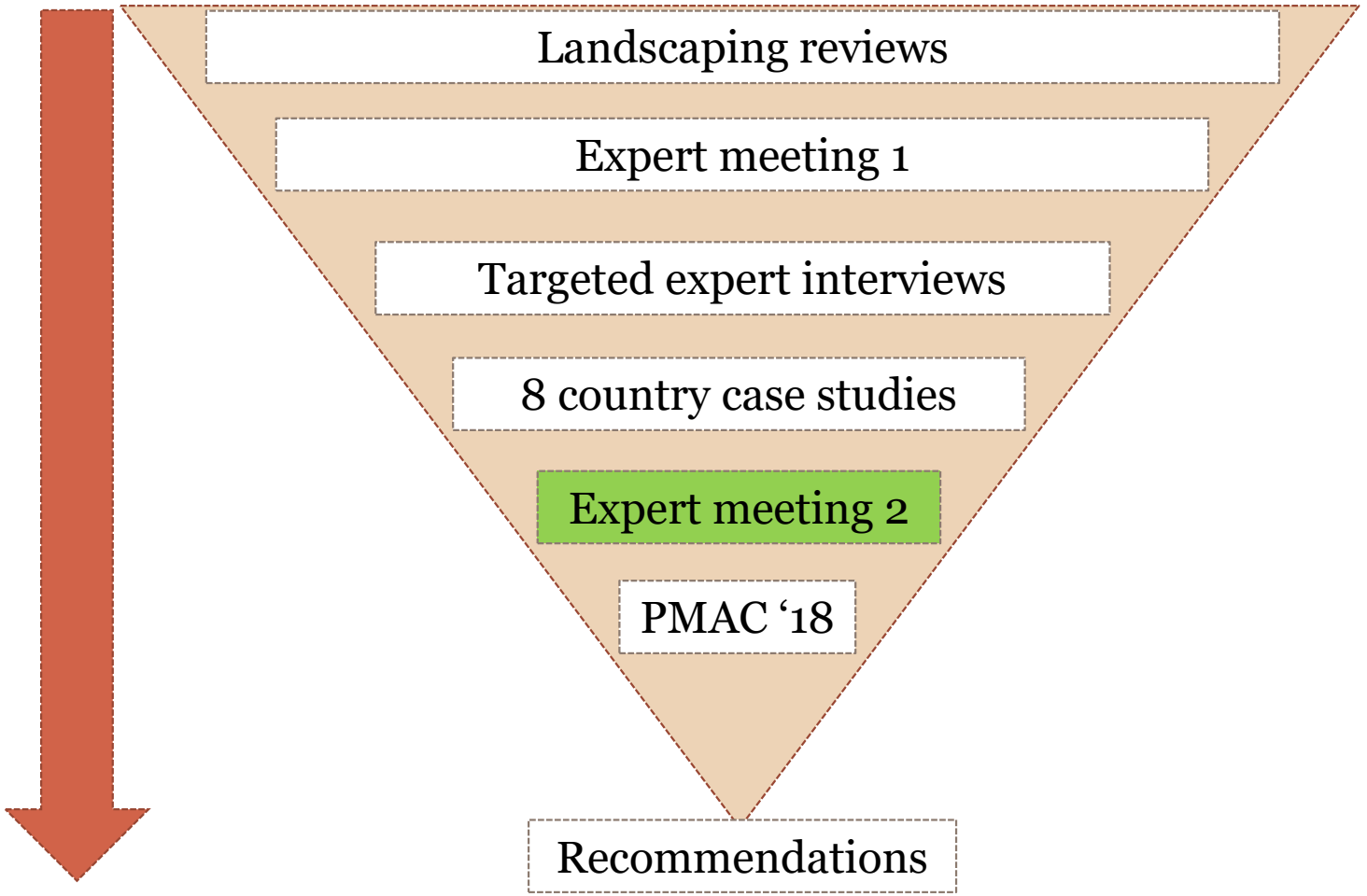
- **Ethiopia**: Health Extension Programme
- **Bangladesh**: Sector Wide Approach (SWAP) and community clinics
- **Cambodia:** Health Equity Fund and Social Operating Agency
- **Georgia**: hospital privatization and health sector financing
- **Nepal**: integrated management of neonatal and childhood illness (IMNCI)
- **Solomon Islands**: Role Delineation Policy (RDP)
- **Burkina Faso**: health financing reforms and the Mutuelles de Santé
- **Rwanda**: community-based health insurance (CBHI) and performance-based financing (PBF) in Rwanda

Included health financing (6), organisational (4), service delivery (2), and human resources for health (1) reforms (although many cross-cut)

8 country case studies

- Range of influences in relation to conceptualisation, from externally imposed to co-produced and finally home-grown solutions.
- Uptake of policy was strongly driven in most settings by local political economic considerations.
- Policy development post-adoption demonstrated some strong internal review, monitoring and sharing processes but there is a more contested view of the role of evaluation.
- Direct personal relationships with local development partner staff can be a key facilitator.
- Many countries appeared to feel that other country experiences were less relevant to them once they were into the operationalisation state. Much more open at conceptualisation stage.
- The findings emphasise the agency of local players and the importance of developing national and sub-national institutions for gathering, filtering and sharing evidence.

The process of identifying strategic interventions



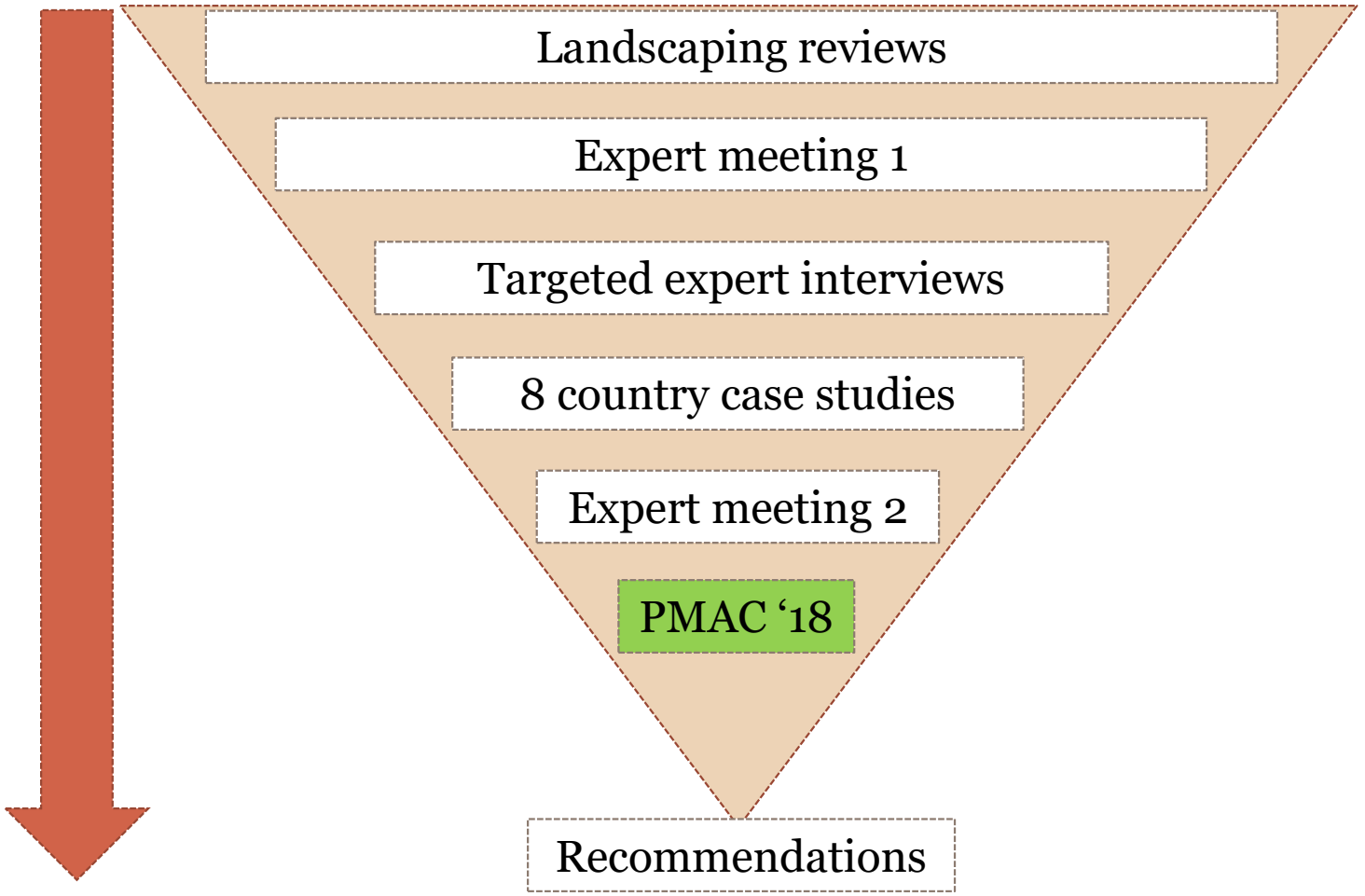
Expert meeting 2

- Twenty-four experts, selected for their knowledge of policy and learning processes, both in their own countries and internationally, from 20 Anglophone, Francophone, and Lusophone countries in Africa participated.
- The divide between Anglophone and Francophone debates was clear.
- The opportunities and constraints of using the internet was a big theme.
- Role that culture plays in lesson-learning. Experts suggested this was a very broad area, but included themes such as leadership and governance, protective ownership of information etc.
- Existence of an assumption that ‘our setting is unique and it's not clear whether lessons from other countries are relevant’.
- The importance of learning for a purpose, and linking that purpose to sector implementation plans. A ministry should plan what it wants to learn, and that should relate to what it wants to achieve.

Expert meeting 2

Possible platform to support	Overall score
Strengthening sub-regional centres of excellence	462
A database for exchange of operational tools and experience	431
A responsive fund for country-specific health system research projects	397
Small, long-term partnership development	350
African health system learning networks	345
Strengthening the African Health Observatory	312
In-depth evaluation of existing platforms	262

The process of identifying strategic interventions



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Proposal 1: an 'African Observatory'?

Ian Anderson
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29 January 2018

I will discuss:

- What is a Health “observatory”
- What “success” looks like: an example of an observatory that generates evidence and facilitates learning between countries.
- The case for strengthening the existing African Health Observatory (AHO) through some proof of concept, performance based, phased investments.
- Risks / other options.

From astronomical observatory to “health observatory”.

‘Health observatory’ first used in France in 1974.

The purpose of an observatory is
“ to stand back from phenomena and events, providing objective description and analysis, and forecasting of patterns, interrelationships, processes and outcomes.”

Source: Hemmings J and Wilkinson J (2003) *What is a public health observatory* Journal of Epidemiology and Public Health.

What is a ‘’Health Observatory’’

- Global health observatories eg:
  - WHO Global Health Observatory Data (monitoring; benchmarking; indicators; analysis and synthesis) http://www.who.int/gho/en/

- Regional health observatories eg:
  - European Observatory on Health Systems and Policy
  - Asia Pacific Observatory on Health Systems and Policy
  - Africa Health Observatory
  - Latin America eg gender and health observatory (PAHO)

- National, sub-national, and disease specific Observatories eg in UK, on obesity etc.

- Common theme: objective, detached, scientific approach; evidence for policy

What might ‘’success’’ look like? The European Observatory on Health Systems and Policies offers some clues.

- Evidence that is useful – *and usable*.
  - Relevant, accurate, timely *and comparable* data that allows successful (and unsuccessful) outriders to be identified.
  - Benchmarking: eg compare the average costs for an age-standardised operation with lowest cost / best practice in other countries in Europe so as to see how far they are from the best practice ‘’frontier’’. Can then ask why?
  - Knowledge broker i.e. convening power (*but* more than ‘just meetings’)
- Policy relevant monitoring, data bases and reporting.
  - Eg regular policy briefs on the impact of the 2008 Global Financial Crisis on health systems in Europe.
  - Reports prepared by consultants and practitioners together.
- Genuine partnership and ‘’ownership’’ between:
  - Nine national European governments;
  - multilateral organisations (EC, World Bank, WHO provides often provides secretariat support);
  - Universities (LSE, LSHTM)
  - stakeholders eg French National Union of Health Insurance Funds.

What the current African Observatory seeks to do now

The AHO states it is ’a web-based platform that serves four functions:

“a) Storage and sharing of data and statistics for elaboration and download if needed;

b) Production and sharing of evidence through the analysis and synthesis of information;

c) Sustaining networks and communities, for better translation of evidence; and

d) Supporting countries establish national or sub-national health observatories.”

https://www.aho.afro.who.int/en/about-african-health-observatory

AHO own advice on its role and publications

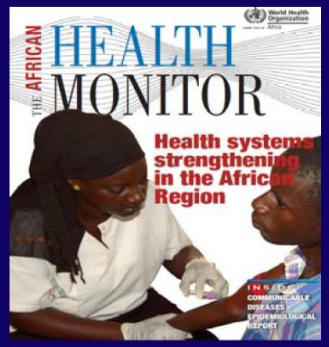
Source: http://www.iapbafrica.co.za/resource/resourceitem/189/1

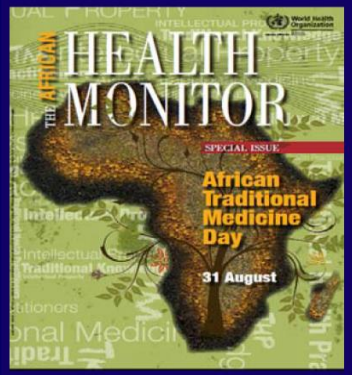
African Health Observatory

World Health Organization
REGIONAL OFFICE FOR Africa

5. Observatory Publications Portal

- **Relevant, high-quality publications on thematic, Regional, sub-regional &/or country-specific issues**
- **Produced by Working Groups or commissioned to consultants**
- **Cleared through AFRO's review process**
- **Linked to related publications**





Some questions about the existing AHO.

- Does it currently have the resources to do those jobs?
  - Staffing *appears* to be limited to a few full-time data managers, and the support of technical experts within the WHO.
  - Financial constraints.

- Is a web based platform effective?
  - Web based platform located in Brazzaville.

- Does it have strong and strategic institutional links?
  - To other governments?
  - To Universities and think tanks?
  - To other relevant stakeholders?

- Does it have existing profile and ‘’brand recognition’’ for policy makers?

The case for working to strengthen the existing AHO

- Builds on an existing institution that has the mandate to facilitate learning (in principle). AHO states it has extensive statistical health profile for each of the 47 Member States of the African Region.

- Avoids duplication and start up costs / delays.

- Builds on links with WHO (WHO is generally well-regarded by stakeholders in SSA).

- If able to fulfil its stated mandate, would respond to the stated needs of stakeholders from Africa including:
  - Need for a trusted clearing house to navigate the existing data and advice.
  - Need for home grown solutions.

- An existing institution means a potential investor could:
  - Quickly support high impact but low cost sharing of evidence and lessons but in a phased, incremental manner.
  - Could then increase / expand further investment support provided there is progress (institutional incentives to show tangible results)
  - Allows for a clear exit strategy for investors particularly if the AHO ‘’succeeds’’.

What would an initial investment in strengthening the AHO buy in terms of outputs and outcomes?

- This first requires a scoping / feasibility study with countries in the region, AHO, and WHO to confirm the specific demand for possible initial investments.

- But illustrative examples of initial first round of investments could include one-off, policy relevant cross-country studies and learning (outputs) on:

  - Clearing house of what is already available.

  - Early production of comparative health system analyses, e.g.
    - What are the African lessons (successes and failures) in retaining the health workforce in rural and remote areas?

    - Which African countries have the highest / lowest cost to government of commonly used drugs? What explains that difference?

    - The quality agenda: which countries are improving the quality of essential health services; how did they do it; and at what cost?

- And what, then, is the evidence that these investments lead to learning and change in other countries (outcome)

And what might the investment buy over the longer term?

Invest so that AHO can fulfil its original mandate (i.e. *enabling* the AHO to do its functions but not necessarily investing directly in the AHO). For example:

- Development and dissemination of specific country health system studies (Ethiopia? Rwanda?) similar to the Health System In Transition (HiT) reports.
  - With a particular focus on then assessing did this stimulate policy discussion and learning in other African countries.
- Seed money to better link AHO with 3-5 university academic centres.
  - Possibly located in regional hubs (eg. Southern Africa, East Africa, West Africa)
  - Focus on evidence synthesis, knowledge generation and knowledge translation.
- Over the longer term, possibly invest in national or regional Centres of Excellence to work with an AHO.
- Could then continue to expand investments *depending upon past performance.*

What would success look like in Africa using AHO?

- Genuine, sustained, learning of successes and failures from other countries in Africa.

- Through (as with the European Observatory):
  - Genuine partnership between governments and reputable organisations with different perspectives and comparative advantage.
  - Producing relevant, accurate, timely and comparable data that allows successful and unsuccessful outriders to be identified.
  - Policy relevant monitoring, data bases and reporting.
  - Specific platform for brokering knowledge and research information.
  - Policy dialogues that bring together national and international experts on specific policy issues and target senior policy makers and top advisors.

- But with investments proceeding in a phased and incremental manner, with subsequent investments dependent upon preceding progress.

Risks, and alternative approaches

- There are several risks / issues including:
  - A strengthened AHO is always a means to an end, not an end in itself.
  - Many examples of multi-country institutional arrangements not being effective or efficient, but still continuing in existence.
  - 'Politics' – but that applies to all options
  - Where has been the demand from African countries themselves for a stronger AHO?
  - Risk of doing nothing?
- Possible alternative approaches:
  - Focus on more bottom-up approach eg strengthening centres of excellence in Africa (next presentation) with an AHO then more of a secretariat.
  - Consider investing in smaller, but possibly more relevant, sub-regional type AHOs (eg East Africa, West Africa, Southern Africa) in conjunction with WHO and Universities in those regions.
  - Others?

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Proposal 2: Centers of International Excellence for health systems learning (CIEHSLs) ("Cecils")

Barbara McPake

29th January 2018

What is a CIESL?

- CIESLs will become experts in the global evidence base around health systems reform, and in supporting the policy stakeholders in their countries to make good use of it.
- They may develop specific expertise – for example in health financing or in health workforce – but they should be generalists in that they understand the linkages between these areas and the whole health system
- They will most likely be located in academic institutions from where they will start with a strong disciplinary base
- But they may be based elsewhere – for example they could grow out of a Ministry of Health's research department
- And in either case, strong partnership between the CIESL, government and other policy stakeholders will be central
- The CIESLs will bring multiple disciplines together to address health systems issues across their breadth
- Their expertise will embrace the issues of translating evidence – contextualization and internalization – and 'brokering' evidence with policy stakeholders as a core activity.

What will the CIESLs do? A selection from a menu of activities

CREATING NEW EVIDENCE

USING EXISTING EVIDENCE

IMPROVING OPERATIONAL CONDITIONS FOR LEARNING

BUILDING OWN CAPACITIES AND FACILITATING CAPACITY BUILDING OF OTHERS

EXAMPLES

- Country health system situation analysis reports (like HiTs)
- Comparative health systems research (potentially in collaboration with other CIESLs)
- Independent evaluation of existing learning platforms (Such as JLN)
- Collation of data to provide engaging snapshots of activities and trends
- Production and dissemination of operational guidelines
- Continuous engagement with policy stakeholders
- Undertaking pilot programs
- Building networks of experts and decision makers
- Organizing and participating in study tours
- Organizing and participating in staff exchanges

How will CIESLs be identified?

- Institutions with an interest in becoming a CIESL will apply for funding to support a range of the activities identified (suggested 5 year horizon)
- They may do this in collaboration with an international institution with expertise and track record in health system learning and a capacity sharing plan
- They may also do so in collaboration with nationally focused institutions outside of Africa who have expertise and track record of supporting policy processes in their own country
- A few CIESLs will be identified at first but over time, a large number of African countries might be covered.

POTENTIAL CRITERIA

- Existing relevant expertise
- Appropriate and credible objectives relevant to the initiative
- A credible 'theory of change' explaining how the CIESL will work with government and other policy stakeholders
- A program of work that fits the context, the expertise of the group, is feasible within the time period and can deliver against the theory of change
- Governance and structural arrangements appropriate to the activities and objectives

Key points of evidence which inspired this proposal

- Centrality of trusted brokers in successful learning examples
- Difficulty of navigating and making judgments across multiple websites and sources of evidence
- Lack of confidence in the relevance of other countries' experiences
- Learning must be 'owned' and acquired within respectful non-hierarchical relationships
- The biggest component of learning is internal contextualization and adaptation
- Learning systems vary, so strategies have to be country specific

- Nationally based institutions can build trusting relationships with policy stakeholders
- A dedicated resource can gain expertise in relation to navigating and judging evidence
- In-depth exposure to, and familiarity with other countries systems will lead to increasing understanding of commonalities
- National ownership and control over activity are central constructs
- Operating at national level allows for significant attention to contextualization and adaptation
- ..and for targeting key elements of national learning processes

Similar initiatives?

- World Bank ACE I and II
  - Focused on supporting excellence in post-graduate training
  - Very successful at national level – enrollments and income generation; less successful at regional level – cross-border participation
  - Approx US$8m/university
- DAAD – partnerships between German and African universities
  - 11 listed
  - Look like exchange programs
  - Funding level not easily found
- African Development Bank – Centres of Excellence in biomedical sciences
  - Eg. East African Oncology Institute (Uganda)
  - Quality enhancement of medical research
  - EAOI receives UAC22.5m (approx US$30m)
- Other differently named models?
  - DFID RPCs?
  - AusAID Hubs?

Supplementary slides from Dr Juma Kariburyo

Resilient Health System -Conceptual Framework – Data collection

Health system strengthening → 6 Building blocs (↗ OFFER?)

1) Service delivery (infrastructures, Health facilities, technical equipment
2) HR (Capacity, Mobility, Retention)
3) Procurement & Supply chain Mgt
4) Strategic Information (inc Research
5) Health Financing
6) Leadership & Governance (Framework, Policy / Plans, Coordination bodies & Mechanisms)

- ↗ Availability of health services
- ↗ Access to health services
- ↗ Coverage (Universal ?)
- ↗ **Quality** (Assurance & Control)
- ↗ **Integration (HIV - TB, HIV- RH)**
- ↗ **Sustainability (political, techn)**

National Response at Program level

1/ Avoid deaths → Treatment & Care
2/ Prevent new cases / complications → Prevention activiti
3/ Epidemiological Surveillance→ Watch system & Early warning system + Monitor Progress/Gaps?
4/ Program Mgt → Governance, Oversight

CRITICAL ENABLERS → ↗ DEMAND?

- Policy & Punitive Laws (HIV-AIDS / MSM)
- Perceived quality by the community? *(traditional birth attendants – traditional practitioners)?*
- Distance to Referral Hospital + transportation costs ?
- Service Utilization
- Task shifting
- Human rights & Equity
- Stigma & Discrimination (KPs?)
- Gender & GBV

↗ Synergy with other development Sectors & ↗ Intersectoral partnership

- Head of State Cabinet
- Parliament
- Justice
- Education
- National Security / Home affairs
- Finance (Domestic funds – ABUJA Declar)
- Social Protection & Poverty reduction
- Agriculture / Human Development
- Media

PARTNERSHIP: Civil society, Private sector & Development Partners, Academia,...

POLICY / PROGRAMS
[↗ Impact]
- HIV/AIDS , TB, MALARIA (GF)
- MCH (incl. PMTCT)
- Epidemic prone diseases
- Non-communicable diseases

SYSTEMS
[↗Performance]
Health system & Community system

ENVIRONME
[↗Synergies]
Intersectoral / Multisectoral Links

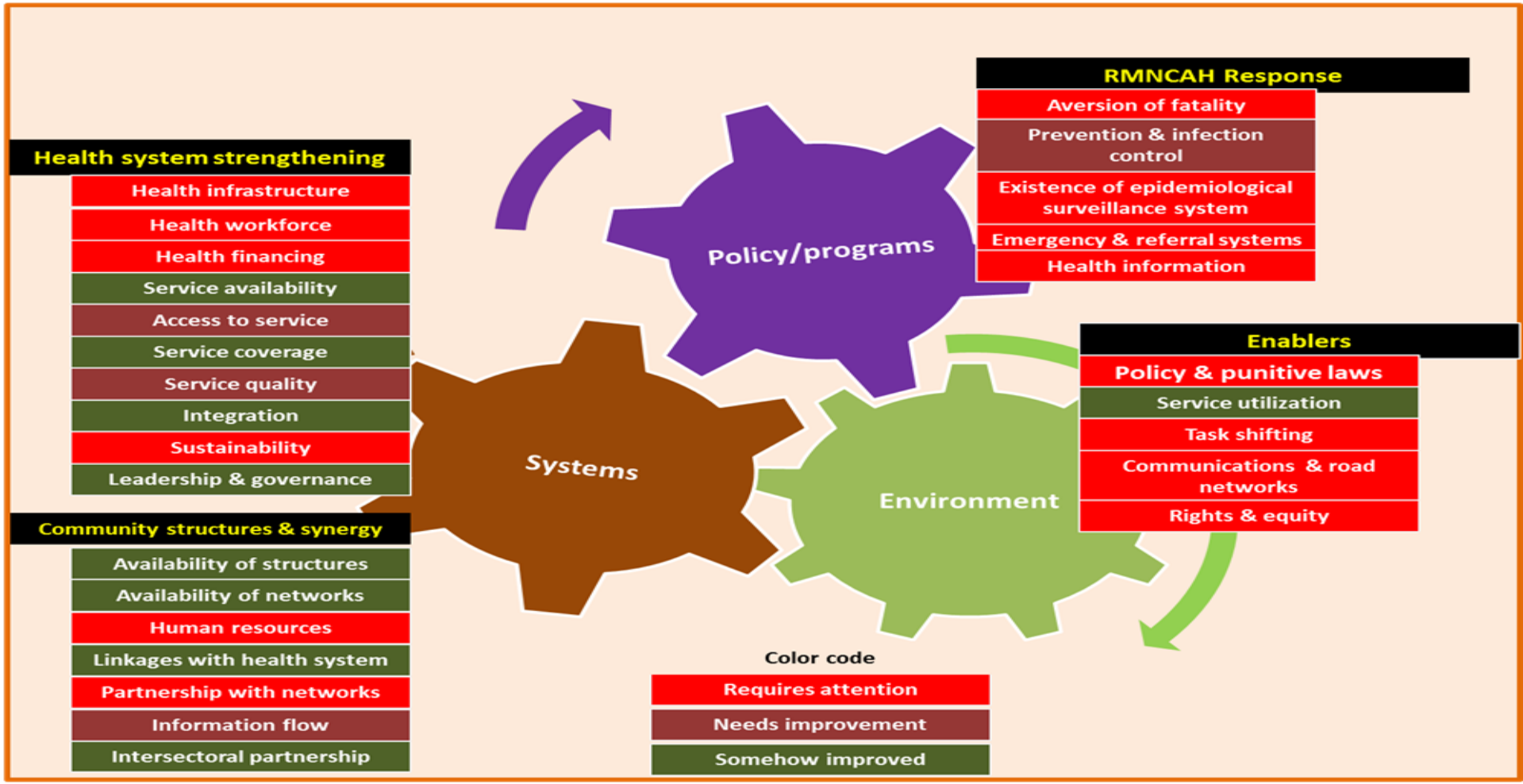
Programmatic Optimization

Community system Strengthening (including Private sector & Faith based Organizations)

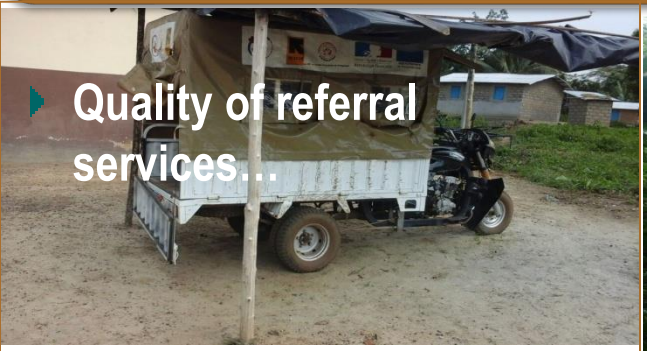
1) Community Mobilisation (Participation, Involvement, Ownership)
2) Service delivery
3) HR
4) Information
5) Social acceptability

Cross Border Health Facility Assessment
In the Mano River Union Region (Sierra Leone, Liberia, Côte d'Ivoire, Guinea)

Whilst best practices were observed at varying degrees across border areas, a number of improvements are required. Areas that need improvement have been aligned with a standard health system framework for RMNCAH



Quality of health service delivery



- Quality of referral services…

- Delay in referrals (markedly observed at health facilities in Guinea (67%) & Liberia) are compounded by the following impediments:
- Poor road networks
- Further distance to referral hospitals- with shortest average distance calculated as 35 km & farthest average distance at 61 km observed for all referrals made across the MRU borders targeted

Delay in finding and providing a rapid and appropriate means of transportation for the transfer: Pending a means of transport ... (Uganda)

Delay in finding and providing a rapid and **appropriate** means of transportation for the transfer (DR Congo)

Delay in the search for and provision of a **rapid** and appropriate means of transport for the transfer (Niger)

29/01/18

RESOLUTIONS

1) **Framework (**Clear definition of the roles and responsibilities of each level of the health pyramid)
2) **Patient Circuit and Minimum Packs Per Level** (Good organization of work in health structures involving a clear division of tasks, roles and responsibilities of each actor by declining a job description for each agent)
3) **Tools** (The referring FOSA establishes an evacuation bulletin or standardized reference sheet (often the only means of exchange and dialogue between providers of the two levels of care about the referred case; a standardized "counter-reference form")
4) **Community involvement**
5) **Patient transportation**
6) **Communication**
7) **Evaluation & Feedback**
8) **Direct Funds to the most efficient systems (Performance)**

RESOLUTIONS

1) **Strengthen national strategic information systems** (generate and share data & evidences on a quaterly basis)

2) Plan for **HR Training & Coaching** (including Community health workers)

3) Set up **National observatory** & **Sub-regional Observatory** → **Audits**
   a) Performance framework + Expected results
   b) Chain of responsibility
   c) Chain of accountability
   d) Chain of evidences (Data collection & Evidence generation)
   e) Produce, Assess and Share best practices + Countries to learn from each other

4) Plan for **biannual meeting of technicians** to discuss progress and obstacles on one hand, and learn from each other on the other hand (including the **organization of study tours**)

5) Plan for **a meeting of decision-makers and parliamentarians from the 4 member states** to share the main figures and evidences and to make them decisions based on concrete facts and better guide use of the few funds available (recalling that all these deaths could be avoided)

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Thank you